



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ACCESS MEDIQUIP
PO BOX 421529
HOUSTON TX 77242

Respondent Name

LM INSURANCE CORP

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-13-0386-01

MFDR Date Received

OCTOBER 5, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I was advised by Ms. Michelle of Liberty Mutual today that Mr. John Inseo is adamant that Access Mediquip's claim will not be adjusted for payment when the surgery center change their mind about separate reimbursement to third party for implant. I would like to explain to him that the surgery center sent Access Mediquip the request to provide and bill separately for the medically necessary implant. Based on the agreement with the surgery center, Access Mediquip submitted a Purchas Order to the implant vendor and was invoiced by the vendor for the implant. Access Mediquip then paid the implant vendor for the implant used on the claimant. Access Mediquip complied with the rule set forth by the TX WC regulation; however, the surgery center failed to indicate separate reimbursement to third party and they go paid at higher rate even if they did not provide nor bill for the implant. In this case the surgery center had resubmitted their bill to correct the error they made but Liberty Mutual still won't adjust Access Mediquip's claim."

Amount in Dispute: \$1,692.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The facility, Baylor Ortho and Spine Hospital was paid the full fee schedule allowance of 200% to include implants as their UB04 billing form indicates.... The below information regarding separate implant payment is with regards to the ASC fee schedule, however; as similar situation indicated, I feel this would also be applicable to hospital facilities as the same TDI rules for separate implant reimbursement are applicable... 10. What are the payers options if the ASC does not include any information requesting separate reimbursement for implantables, but the payer then receives a bill for implantables from a surgical implant provider? Since separate reimbursement is the election of the ASC, the payer would pay the ASC the appropriate multiplier that includes reimbursement for the implantable, but would deny the bill from the surgical implant provider."

Response Submitted by: Liberty Mutual Insurance, 303 Jewell Parkway SE, Ste. 500, Gainesville, GA 30501

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 3, 2011	HCPCS Code L8699	\$1,692.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated

- X122 – The value of the total procedure was paid to another provider.
- 193 – Original payment decision is being maintained, it was determined that this claim was processed properly.
- Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered.
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due.
- Z951 – Additional allowance not recommended per fee schedule, usual and customary guidelines and-or provider's PPO contract.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is October 3, 2011. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on October 5, 2012. This date is later than one year after the date of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

September 19, 2013

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.